MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

FINDING OF EMERGENCY
ER-1-08
Community Provider Plan Designation Timeline

FINDING OF EMERGENCY

At its March 19, 2008 meeting, the Managed Risk Medical Insurance Board (MRMIB) found that an emergency exists and that the immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety, or general welfare. The Board also determined that it is not required to provide notice pursuant to Government Code section 11346.1(a)(2) because the emergency situation clearly poses such an immediate, serious harm that delaying action to allow public comment would be inconsistent with the public interest. A copy of the Finding of Emergency adopted by the Board is attached.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

MRMIB operates the Healthy Families Program (HFP), which provides health insurance for more than 845,000 low-income children whose family incomes are at or below 250% of the federal poverty level net of applicable deductions and who are ineligible for Medi-Cal because their family income exceeds Medi-Cal income eligibility limits. (Insurance Code section 12693 et seq.) MRMIB provides the coverage to eligible children by contracting with health plans. (Ins. Code section 12693.26.) Participating health plans, in turn, contract with providers to provide the medical services. In its selection of participating plans, the Board must include plans that have contracts with traditional and safety net (T&SN) providers. (Ins. Code section 12693.37(b).) T&SN providers are those which historically serve uninsured children, such as free or rural health clinics and county-owned and operated general acute care hospitals.[1]

In each county, the Board must designate a community provider plan (CPP) that is the participating health plan which has the highest percentage of T&SN providers in its network.[2] Applicants selecting CPPs are given a family

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[1] The types of T&SN providers are more fully described in section 2699.6805(c).

[2] The term "community provider plan' means "that participating health plan in each geographical area that have been designated by the board as having the highest percentage of traditional and safety net provides in its provider network." (Ins. Code section 12693.045.) The Board has determined that the applicable geographic area for the CPP designation is each county. (Cal. Code Regs., tit. 10, sec. 2699.6805.)

contribution discount on their premiums. (Ins. Code section 12693.43(d).) The discount is subsidized by MRMIB. The process gives an incentive for the plans to compete for the CPP designation because the family discount encourages applicants to choose the CPP.

The CPP designation process is designed to promote important goals in providing health care to low-income children: (1) stability for the T&SN providers, which historically provide services to HFP-eligible children, (2) continuity of care for newly enrolled HFP subscribers because such subscribers are likely to have been uninsured and, therefore, more likely to have used T&SN providers, and (3) provision of care by providers which have cultural and linguistic competencies appropriate to the HFP-eligible population since T&SN providers are more likely to be located in areas which reflect HFP-eligible subscribers' cultural and linguistic characteristics.

The HFP regulations set forth the process for the health plans' submission of data that MRMIB considers to determine which plan has the highest percentage of T&SN providers.[3] Under section 2699.6805(f), the Board must designate the CPP by March 31, 2008 for the next benefit year. The timing of the designation is tied to the timing of the Board's annual determination of the family value package because only plans that are part of the family value packages may participate in HFP. The family value package is the lowest-cost combination of health, dental and vision plans as well as certain additional plan combinations that are within a stated percentage of the cost of the lowest-cost combination.[4] Under the current HFP regulations, the Board must make the family value package determinations once each year by the last day of March for the next benefit year. The family value package designation is an integral part of rate negotiations for the following benefit year so its timing must coordinate with rate negotiations and the related administrative processes such as plan open enrollment. However, as described below, the requirement of announcing the CPP designation and the family value package determination by March 31 of this year would cause substantial harm to applicants and subscriber children.

On January 10, 2008, the Governor declared a "State of Fiscal Emergency" due to an estimated $14.5 billion deficit in the state's General Fund. On the same day, the Governor released a proposed 2008–09 fiscal year budget that calls for

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[3] See, Cal. Code Regs., tit. 10, sec. 2699.6805.

[4] By state statute, in combination with the federal government's interpretation of applicable federal law, MRMIB may not contract with health, dental and vision plans if the resulting plan combinations are priced too high to be designated as family value packages. (Ins. Code secs.12693.065, 12693.43.) While the HFP statute reads as if MRMIB may offer plans that cost more than a family value package and charge subscribers the difference, in reality the federal Centers for Medicare and Medicaid Services [CMS] rejected that portion of California's proposed State Plan at the inception of the program. Therefore, MRMIB may not contract with any health, dental or vision plan that is not part of a family value package.

a 10% across-the-board reduction in state General Fund expenditures. The Governor's plan calls for a 6.25% reduction of current contract capitation payment rates for HFP participating health, dental and vision plans.[5] The Governor also called for the Legislature to pass legislation by March 1, 2008 in order to implement the rate reduction effective July 1, 2008. In the past, the effective date of contract amendments has been July 1 for a one-year term, which is congruent with the benefit year. The Legislature is considering the Governor's proposals and no enabling legislation has yet been passed. Because of the fiscal uncertainty, at its March 19, 2008 meeting, the Board decided to suspend its usual contracting process, extend current contracts for a limited period, and delay open enrollment until final action on the budget has occurred. [6]

It would be harmful for the Board to announce the CPP by March 31 this year or to award the CPP designation for the entire benefit year. Neither the Board nor the plans will know the amount of the rate reduction until the budget and associated legislation are passed. If a plan is competing for the CPP designation in a county based on its current reimbursement rate and the rate is reduced, the plan may determine not to continue to provide coverage in the county. A decision by a plan not to provide coverage in a particular county fundamentally impacts the CPP designation process because it affects the availability of plans to serve as CPPs in each county. Therefore, MRMIB cannot designate a CPP in a county until it determines which plans will be serving a particular county unless it is willing to undertake the CPP designation process twice, at considerable administrative cost and disruption to subscribers.

MRMIB has decided that it must delay the annual open enrollment process and wait to inform applicants of their choices until it knows which plans serve which counties. Importantly, the Board cannot inform applicants of the costs to them in each county until the CPP designation process is complete. As noted above, subscribers who choose the CPP pay a lower premium than those who select a different plan. In addition, the Governor's proposed budget also includes a premium increase for applicants with incomes above 150% of the federal poverty level. If the premium increases are approved, it is likely that the discount will be even more important to applicants.

The uncertainty caused by the budget crisis also requires the Board to make two regulatory changes to reflect its decision not to enter into contact amendments for a twelve month period. Normally, the family value package calculation is based on rates submitted by, and negotiated with, plans. It is an integral part of

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[5] The Governor called for a five percent reduction in capitation payments to health plans. In addition, the Governor has called for an increase in copayments for non-preventive services for families with incomes over 150 percent of the federal poverty level. MRMIB estimates that will reduce health plan rates by 1.25 percent.

[6] The open enrollment process is described in Cal. Code Regs., tit. 10, sec. 2699.6621.

the board's rate negotiations and ultimate decisions about whether the Board will renew a plan for each subsequent plan year. The uncertainty caused by the budget crisis and pending proposals makes it impossible for MRMIB to perform the family value package calculation based on rate negotiations that cannot happen until a later date and that, based on the Governor's proposed budget, might not happen at all. In addition, the regulations must clarify that plan rates are established for each contract term instead of a twelve month period.[7]

In conclusion, an emergency exists because the uncertainly caused by the budget crises makes it impossible for MRMIB to go forward with the CPP and family value package designation processes within the timelines established in the current regulations. The immediate adoption of the attached proposed regulations is necessary to avoid serious harm to the public peace, health and safety, or general welfare by providing the Board with flexibility to determine when to designate the CPP and the family value package instead of the present requirement of making such a determination by March 31. A Board CPP designation by March 31, 2008, with a July 1, 2008 effective date, would require the Board to use scarce resources later to change designations in some counties and potentially repeat the open enrollment process. Changing CPP designations twice – once effective July 1, 2008 and once when MRMIB has a final list of participating plans - would be disruptive to applicants who maintain their children's enrollment in the cheaper CPP and would confuse and burden applicants. Such actions would seriously harm applicants and subscriber-children receiving HFP coverage. Similarly, performing the family value package determination in each county simply is not possible at this time because of the uncertainty, described above, engendered by the fiscal crisis and ongoing legislative and gubernatorial decision-making.

AUTHORITY AND REFERENCE CITATIONS

Authority: Insurance Code section 12693.21

Reference: Insurance Code sections 12693.21, 12693.37, 12693.43 and 12693.065.

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Existing Law: MRMIB operates HFP to provide health insurance coverage for low-income uninsured children. The coverage is provided by contracting with health plans. By statute, MRMIB must take steps to assure a range of choices

[7] By statute, MRMIB negotiates rates with each health, dental and vision plan, with the outer limit on rates determined by the family value package determination. While normally rates are negotiated for a twelve-month period, this is not required by law. In view of the uncertainty about plan rates and the contracting process caused by the current budget crisis, MRMIB's rating process will not automatically align with a 12-month cycle.

available to applicants and it must include plans that include provider networks have signed contracts with T&SN providers. In each county, the Board must designate a CPP. Applicants selecting a CPP plan are given a family contribution discount. Existing regulations require the Board to designate the CPP plan by March 31 of each year.

Existing law provides that the family value package is the lowest-cost combination of health, dental and vision plans as well as certain additional plan combinations that are within a stated percentage of the cost of the lowest-cost combination. Existing regulations requires that the Board to make the family value package determinations once each year not later than the last day of March for the following benefit year based on calculations using the prices of the plans that the calculations are expected to be available for the following benefit year.

Existing law provides that health, dental and vision benefit plan rates shall be established for each rating period and that the rating period for the program shall be established for a twelve month period.

A summary of the proposed regulations' effect on existing law and regulations is as follows:

2699.6500

The section requires that the Board to make the family value package determinations once each year not later than the last day of March for the following benefit year based on calculations using the prices of the plans that the calculations are expected to be available for the following benefit year. The proposed regulation retains the requirement of the current regulation that, when the Board calculates the family value package, it shall base the calculation on the prices expected to be available for the time period for which the family value package designation is made; but it deletes the reference to a specific time for the annual designation.

2699.6803.

The section provides that health, dental and vision benefit plan rates shall be established for each rating period and that the rating period for the program shall be established for a twelve month period. The proposed regulation would provide that rates will be established for each contract term.

2699.6805(f).

Section 2699.6805(f) requires the Board to designate a CPP for each geographical service area by March 31 of each year. The proposed regulation would remove the requirement that the Board to designate the CPP by that date. The proposed regulation would provide the Board with flexibility as to when it designates the CPP. To avoid confusion, the proposed regulation would provide that CPP designations do not necessarily coincide with the July 1 to June 30 benefit year. Instead, the effective date would be tied to the effective date of the transfers of enrollment as a result of the open enrollment process.

Policy Statement: The objectives of the proposed regulations are to (1) provide the Board with flexibility to determine when it designates the CPP and family value packages, (2) provide that rates are established for each contract term, and (3) provide applicants with choices of plans reflecting the CPP discount in a manner to avoid disruption to families or endure needless programmatic costs.

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT

"The Managed Risk Medical Insurance Board 2008-09 Governor's Budget Overview"; Medical Risk Medical Insurance Board, January 16, 2008 Board Meeting, Item 4.

DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: No.

Mandates on Local Agencies or School Districts: None.

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None.

Non-discretionary Costs or Savings Imposed on Local Agencies: None.

Costs or Savings to Any State Agency: None.

Costs or Savings in Federal Funding to the State: None. The proposed regulation would simply provide the Board with flexibility as to when the CPP designation must occur.

STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 1. DEFINITIONS
AMEND SECTION 2699.6500 (r)

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Section 2699.6500 is amended to read:

2699.6500. Definitions.

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(r) "Family value package" means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is

the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. ~~The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year.~~ *When the Board calculates the family value package, it shall base the calculation on the plan prices expected to be available for the anticipated health, dental and vision plan contract terms.* Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

* * * *[continued]*

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS
AMEND SECTIONS 2699.6805(f) and 2699.6803

Text

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Section 2699.6803 is amended to read:

2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each *contract term* ~~rating period and the rating period for the program shall be a twelve (12) month period~~.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

Section 2699.6805 is amended to read:

2699.6805. Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health *Care* Services ~~(DHS)~~*(DHCS)* CHDP Master File as of October 1st of that year and which provided a State-Only

Funded CHDP service as identified on the CHDP Paid Claims Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county, which were so identified by the Medi-Cal program as of October 1st of that year and which were identified on the Medi-Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each clinic, the list shall indicate a percentage which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health *Care* Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi-Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment

program as reported by the ~~DHS~~ *DHCS*, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall ~~announce~~ *designate a* ~~the designation of the~~ community provider plan for each county ~~by March 31st of each year~~ for the benefit year ~~beginning on the next July 1st.~~ *described in subsection (a). Notwithstanding subsection (h) of section*

2600.6500, the designation shall take effect on the day the open enrollment transfers described in section 2699.6621 take effect, and the previous designation shall remain in effect until that time. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to(c)(1) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21 and 12693.37, Insurance Code.